



# GROUP APPLICATION FOR EMPLOYEE BENEFITS

[P.O. Box 1650]  
[ Little Rock, AR 72223]

INTERNAL USE ONLY	
POLICY NUMBER	_____
PROPOSAL NUMBER	_____

Please Type or Print in Black Ink

REQUESTED EFFECTIVE DATE
GROUP APPLICATION FOR POLICY EFFECTIVE DATE* _____ <i>*The effective date is subject to approval by US Able Life. We will notify you in writing if not approved.</i>

EMPLOYER INFORMATION	
<b>1. LEGAL NAME OF GROUP</b>	
<b>2. TAX ID NO.</b>	
<b>3. STREET ADDRESS</b> (STREET/CITY/STATE/ZIP)	
<b>4. MAILING ADDRESS</b> if different from street address (STREET/CITY/STATE/ZIP)	
<b>5. EMPLOYER IS A:</b> <input type="checkbox"/> Sole proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> LLC <input type="checkbox"/> Other _____	
<b>6. NATURE OF BUSINESS</b>	<b>7. ELIGIBLE EMPLOYEES</b>
<b>8. SUBSIDIARIES/AFFILIATES TO BE COVERED?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please list all names and locations in the space below. SUBSIDIARIES/AFFILIATES NAMES & LOCATIONS: _____	
<b>9. ARE THERE EMPLOYEES LOCATED IN OTHER STATES?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please list all names and locations in the space below. STATES WHERE EMPLOYEES RESIDE: _____	
<b>10. ARE DOMESTIC PARTNERS ELIGIBLE FOR DEPENDENT COVERAGE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	

EMPLOYER CONTACT INFORMATION:			
BENEFIT CONTACT INFORMATION:		BILLING CONTACT INFORMATION:	
NAME (First, Last)		NAME (First, Last)	
PHONE	FAX	PHONE	FAX
EMAIL		EMAIL	



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EMPLOYER INFORMATION	
LEGAL NAME OF GROUP	TAX ID NO.

EMPLOYEE CLASS DEFINITIONS		
CLASS	DESCRIPTION OF CLASS(ES)	ELIGIBLE EMPLOYEES
1		
2		
3		
4		

ELECTED PRODUCTS <sup>1</sup>	MIN HOURS	CONTRIBUTION		ENROLLED EMPLOYEES
			EMPLOYER %	
BASIC LIFE		<input type="checkbox"/> PRE-TAX <input type="checkbox"/> POST-TAX		
BASIC AD&D		<input type="checkbox"/> PRE-TAX <input type="checkbox"/> POST-TAX		
SUPPLEMENTAL LIFE <sup>2</sup>		<input type="checkbox"/> PRE-TAX <input type="checkbox"/> POST-TAX		
SUPPLEMENTAL AD&D <sup>2</sup>		<input type="checkbox"/> PRE-TAX <input type="checkbox"/> POST-TAX		
DEPENDENT LIFE <sup>2</sup>		<input type="checkbox"/> PRE-TAX <input type="checkbox"/> POST-TAX		
VOLUNTARY LIFE		<input type="checkbox"/> PRE-TAX <input type="checkbox"/> POST-TAX		
VOLUNTARY AD&D		<input type="checkbox"/> PRE-TAX <input type="checkbox"/> POST-TAX		
BASIC/CORE STD <sup>3</sup>		<input type="checkbox"/> PRE-TAX <input type="checkbox"/> POST-TAX <input type="checkbox"/> GROSS-UP		
BUY UP STD <sup>2</sup>		<input type="checkbox"/> PRE-TAX <input type="checkbox"/> POST-TAX <input type="checkbox"/> GROSS-UP		
VOLUNTARY STD <sup>3</sup>		<input type="checkbox"/> PRE-TAX <input type="checkbox"/> POST-TAX <input type="checkbox"/> GROSS-UP		
BASIC/CORE LTD <sup>3</sup>		<input type="checkbox"/> PRE-TAX <input type="checkbox"/> POST-TAX <input type="checkbox"/> GROSS-UP		
BUY UP LTD <sup>2</sup>		<input type="checkbox"/> PRE-TAX <input type="checkbox"/> POST-TAX <input type="checkbox"/> GROSS-UP		
VOLUNTARY LTD <sup>3</sup>		<input type="checkbox"/> PRE-TAX <input type="checkbox"/> POST-TAX <input type="checkbox"/> GROSS-UP		

1. If effective date, anniversary or renewal dates vary by product please note in remarks.  
 2. Not available on stand alone basis.  
 3. STD and LTD benefits that are paid for with pre-tax dollars will be subject to the federal insurance contributions act (FICA) and/or federal income tax (FIT).

REPLACEMENT: ARE ANY OF THE FOLLOWING A REPLACEMENT OF SIMILAR COVERAGE?				
	Yes	No	If yes, Previous Carrier	Termination Date
BASIC LIFE	<input type="checkbox"/>	<input type="checkbox"/>		
SUPPLEMENTAL LIFE	<input type="checkbox"/>	<input type="checkbox"/>		
VOLUNTARY LIFE	<input type="checkbox"/>	<input type="checkbox"/>		
STD / VOLUNTARY STD	<input type="checkbox"/>	<input type="checkbox"/>		
LTD / VOLUNTARY LTD	<input type="checkbox"/>	<input type="checkbox"/>		

If prior coverage, include a copy of the prior carrier's plan.



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## EMPLOYER INFORMATION

LEGAL NAME OF GROUP

TAX ID NO.

## EMPLOYEE MANAGEMENT PROVISIONS

### SALARY BASED PRODUCTS

Salary changes for group products will take place on the:

- FIRST OF THE MONTH FOLLOWING    DATE OF CHANGE    ANNIVERSARY   *NOTE: Reductions in coverage due to age will always occur on the date of change.*

## ELIGIBILITY

### EMPLOYEE WAITING PERIOD

First of policy month following completion of \_\_\_\_\_ days of continuous active work

Day following completion of \_\_\_\_\_ days of continuous active work

Waiting period applies to:  Current Employees    Future Employees

### ELIGIBILITY PERIOD FOR REHIRS: SELECT ONE OF THE DURATIONS BELOW

The waiting period is waived for employees rehired within:

- 3 MONTHS    6 MONTHS    12 MONTHS    OTHER \_\_\_\_\_    WAITING PERIOD APPLIES

## BILLING

### Group will be billed by:\*

- USABLE LIFE ONLINE BILLING  
 COMBINED BILLED WITH BLUE PLAN  
 SELF BILLED (Policyholder or Third Party Administrator)  
 OTHER

*\*If billing varies by product please note in remarks.*

*Annual enrollment and policy anniversary effective date for voluntary coverage will match policy effective date if not otherwise noted.*

### Billing method will be:

- ADVANCED (ie. bill generated 15th of August for September premium)  
 10 MONTHS (List months skipped) \_\_\_\_\_  
 9 MONTHS (List months skipped) \_\_\_\_\_  
 OTHER

## W-2 SERVICE OPTIONS FOR STD AND LTD:

OPTION 1: Withhold the employee's portion of FICA. Prepare and file W-2 Forms.    STD    LTD

OPTION 2: Withhold the employee's portion of FICA. Policyholder responsible for W-2 Forms.    STD    LTD

If Option 1 or 2 are chosen, employer appoints USable Life, or its assignee, as its agent to handle tax withholdings. If Option 1 is chosen, employer appoints USable Life or its assignee, as its agent to make W-2 Form filings.

*A description of the W-2 and FICA services elected by policyholder pursuant to this application will be sent to the policyholder by mail. Such services will be performed to accordance with the above election and the terms of the W-2/FICA service agreement.*



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REMARKS/SPECIAL PROVISIONS:

US Able Life will issue a policy if we approve this application and the policyholder provides us with all new business submission information required to administer the policy. The applicant agrees that acceptance of the policy will be an approval of the policy terms.

This application is governed by the laws of the state of [state].

**WARNING:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

The information represented in this application is accurate to the best of my knowledge. I understand and agree that if the information contained in the accompanying proposal is different than this application, the information in the application will be used by US Able Life to implement this plan.

## SIGNATURES

NAME OF LEGAL REPRESENTATIVE OF POLICYHOLDER (PRINTED)

TITLE OF LEGAL REPRESENTATIVE OF POLICYHOLDER

SIGNATURE OF LEGAL REPRESENTATIVE OF POLICYHOLDER

SIGNED AT (CITY, STATE)

DATE

NAME OF POLICYHOLDER AGENT (PRINTED)

SSN/TAX ID NUMBER

STATE ID NUMBER

SIGNATURE OF POLICYHOLDER AGENT

SIGNED AT (CITY, STATE)

DATE